STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004811	A. BUILDING: _____ B. WING _____	09/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL INDIANA AMG SPECIALTY HOSPITAL LLC	2401 W UNIVERSITY AVE 8TH FL MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS Surveyor: 33212 Facility #: 152025 Type of Survey: State Licensure Off-Site HFAP Accreditation Survey Date of ISDH off-site review: 9/3/2013 Based on review of the 9/27/-9/28/2012 HFAP Survey Report, it has been determined that AMG Specialty Hospital of Muncie meets the requirements for State Licensure in Indiana for 2012.	S 000		